Consulting
Health and Benefits

Kansas Department of Health and Environment

Analysis of Affordable Care Act Impact to Kansas Medicaid/CHIP Program

February 13, 2013

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Executive Summary

The Kansas Department of Health and Environment (State) contracted with Aon Hewitt to perform an independent analysis on the potential enrollment and budget impact of the Affordable Care Act (ACA) implementation to the State's Medicaid/Children's Health Insurance Program (CHIP). Several studies have been published by various research entities including the Kaiser Family Foundation, Kansas Policy Institute, and Kansas Health Institute in the past several years. As expected, the results vary due to the use of different approaches and data sources.

Aon Hewitt reviewed related studies including national studies and technical assistance guidance in addition to the three studies mentioned above and developed its own approach to model the potential impact of ACA implementation to Kansas's Medicaid/CHIP program. We modeled the impact by developing experience-based enrollment rate assumptions for those currently eligible for Medicaid/CHIP and for those who will be newly eligible under the expansion option using detailed eligibility and enrollment information provided by the State as well as census data and other data sources. The incremental increase of the projected enrollment rates under various ACA scenarios allowed Aon Hewitt to further differentiate the woodwork impact if there were no expansion, as well as determine the additional woodwork impact under the expansion scenario.

Assuming moderate statewide population growth will continue, and using the CY2010 Medicaid/CHIP enrollment experience as a base, our best estimate if the State chooses not to expand Medicaid, is that the Medicaid/CHIP enrollment will increase by 20,563 in CY2014, ramping up to 41,538 (23,740 for Medicaid and 17,798 for CHIP) by CY2016, when the ACA is expected to be fully implemented. The increase in enrollment without expansion is assumed to occur due to outreach efforts under ACA implementation, regardless of expansion. This expected increase in enrollment for those who are currently eligible but not enrolled in the Medicaid/CHIP program is commonly referred to as the woodwork effect. The anticipated 10-year (CY2014-CY2023) State budget increase (state share only) for no expansion will be $513.5M ($455.5M for Medicaid and $58.0M for CHIP).

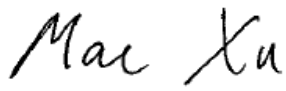
If the State chooses to expand Medicaid, Aon Hewitt's best estimate is that the Medicaid/CHIP enrollment will increase by 111,880 in CY2014, ramping up to 226,003 (25,416 from currently eligible Medicaid, 49,384 from currently eligible CHIP, and 151,203 from those newly eligible for Medicaid) in CY2016, once ACA is fully implemented. These estimates incorporate anticipated woodwork effects, newly eligible members and potential crowd out effects. Crowd out refers to enrollment shifts from private coverage to public insurance as an effect of Medicaid eligibility expansion. Under the expansion scenario, the enrollment of currently eligible but not enrolled is assumed to increase more than under the without expansion scenario. This is due to extra outreach efforts initiated by various interest groups and anticipated additional enrollment of currently eligible children when newly eligible parents enroll in Medicaid. The enrollment increase from the newly eligible is mainly driven by the expansion of Medicaid eligibility to all eligible individuals under 138% of the federal poverty level (FPL), regardless of parental status or medical condition. The anticipated 10-year (CY2014-CY2023) State budget increase (state share only) with expansion compared to No ACA will be $1.1B ($970.1M for Medicaid and $173.6M for CHIP).

The best estimate reflects our interpretation of the available data and our best assumptions regarding how various eligible beneficiaries will react to the implementation per our discussion with the State. The

budget impact did not account for possible options to reclassify some currently eligible beneficiaries to newly eligible status to gain higher Federal Medical Assistance Percentage (FMAP) funding or potential reductions in state-only programs, and it also did not account for additional administrative costs associated with an expansion. Our enrollment and budget impact also assumed that ACA implementation has no material impact to those individuals age 65 and over.

Actuarial Certification—Statement of Opinion

The analysis was performed by Mac Xu, FSA and MAAA, and professionally reviewed by Kirsten R. Schatten, ASA and MAAA. We followed generally accepted actuarial principles in performing this analysis and are reasonably familiar with ACA rules and the Kansas Medicaid program. We both meet the qualification requirements to issue this report. The results were based on our best interpretation of the data available to us and our best knowledge of how eligible beneficiaries will react to the implementation of ACA in Kansas. We relied on the accuracy and completeness of the data provided by the State. We reviewed the data for usefulness and reasonableness and took a conservative approach in the use of the data, especially the census data. However, if the data is not accurate or the enrollment experience has changed significantly since the base period we used, our results are likely to change.



February 13, 2013

Mac Xu, FSA, MAAA — Date

Professionally Peer Reviewed By:

February 13, 2013

Kirsten R. Schatten, ASA, MAAA — Date

Data

Aon Hewitt used the following data to perform this analysis:

- Monthly average Medicaid/CHIP enrollment counts by county, aid category, and age group for CY2010 from the State;
- Actual capitation rates and projected member counts by region and detailed rate cell for CY2013 and CY2014 from the State;
- 5-year projection (CY2013-CY2017) of Medicaid/CHIP enrollment and budget under 1115 waiver from the State;
- State specific Current Population Survey (CPS) data for 5-year average (2007-2011) income distribution by age group; and
- State specific Census data for CY2010 population counts by age group and other demographics.

We used State provided CY2010 enrollment data to identify the number of individuals actually enrolled for each of the following major eligibility groups: TANF-Children, TANF-Adults (age 19-64), CHIP-Children, Non-TANF Medicaid Children, and Non-TANF Adults. We excluded those aged 65 and over since we do not expect any material enrollment or budget impact for this age group during the period of evaluation.

We used State provided capitation rates and projected enrollment for CY2014 to develop the weighted average CY2014 capitation rates for each of the major eligibility groups mentioned above. For Non-TANF Adults, we calculated the average rates for those who are labeled “Regular Non-TANF Adults” separately from the remaining Non-TANF adults who are labeled “Special Non-TANF Adults”. The “Regular Non-TANF Adults” include those individuals who are disabled, pregnant, or medically needy while the “Special Non-TANF Adults” include those individuals with special health care needs or who meet the state’s nursing home level of care requirements. These “Special Non-TANF Adults” are unlikely to produce any woodwork effect under ACA scenarios, regardless of expansion.

As noted above, the State provided 5-year enrollment and budget projections (CY2013-CY2017) for its most recent 1115 waiver. This projection was used to develop the average 10-year per member per year trend assumption specific to the State’s managed care environment. The calculated average annual trend assumption of 2.5% appears to be appropriate considering that almost the entire Medicaid/CHIP program of Kansas will be managed under a capitation model.

Since the current eligibility rules vary by age group, we segmented the total population in each age group by income bands using CPS data to reflect the impact under ACA. While we have a high level of confidence on the accuracy and completeness of the State provided data, we are cautious about the use of census data, especially the CPS data for this analysis. Due to the relatively small sample size used in the CPS (about 31,000 households participated in the annual survey in Kansas), we are not confident that the distribution data for a single year is credible by detailed age group and poverty range level. Therefore, we identified the number of people within a particular poverty range for each of our customized age groups (age under 1, 1-5, 6-18, and 19-64) using a 5-year average (CY2007-CY2011) of CPS data. For example, for age 6-18, we developed the population distribution by the following poverty ranges: 0-105% FPL, 106-138% FPL, 139-237% FPL, 238%+FPL to reflect the State specific eligibility rules for those age 6-18, where Medicaid is currently available for those individuals age 6-18 through 105% FPL, expanded Medicaid will be available through 138% FPL, and CHIP is currently available through 237% FPL. We

included 5% in each FPL threshold to reflect that Kansas Medicaid/CHIP programs allow a certain amount of income deduction for eligibility determination purposes.

We relied on the actual 2010 census data for the statewide population counts by age group. The census also provided estimates of the 2011 and 2012 population for the State of Kansas. Based on this information, we calculated the annual population growth rate of 0.5% and assumed that the growth rate will continue through 2023.

Methodology and Assumptions

To model the enrollment and budget impact of ACA implementation, Aon Hewitt developed an actuarial approach reflecting the State's specific experience with current enrollees and eligible population groups. This approach also recognizes that the Medicaid population is not a homogeneous group in terms of enrollment behavior since eligibility rules vary by age, parental status and medical condition. The approach further reflects the expected differences in enrollment behavior between the Medicaid eligible population and the CHIP eligible population given that CHIP covers children at higher income levels, may require premium payments, and has more stringent enrollment requirements than Medicaid. In addition, the State receives a different Federal Medical Assistance Percentage (FMAP) for CHIP.

All of the assumptions were developed based on the State's actual enrollment experience, supplemented with Aon Hewitt's knowledge of other states' experience and assumptions regarding the enrollment behaviors of the eligible population. This approach was tested for sensitivity to the most likely assumptions, and the range of the results is relatively narrow. Because of this, we have presented the enrollment and budget impacts using best estimate assumptions, rather than providing a range.

The following describes each key step of this approach.

Step 1: Determine key ratios needed for the projection

As the overall population grows, we expect the population distribution by federal poverty level and the population distribution by medical conditions to grow proportionally. In other words, we expect the percentage of the entire population eligible for Medicaid/CHIP to grow at the same rate as the overall population (0.5% annually) assuming no changes to the poverty-based and medical condition based eligibility rules. Therefore, to project the 10-year impact of ACA implementation, the first key ratios are the percentages of entire population eligible for Medicaid/CHIP under the current Medicaid/CHIP eligibility rules and the expanded Medicaid/CHIP eligibility rules. These percentages will be the same for the baseline "No ACA" and the "ACA without Medicaid expansion" scenario, but are expected to be higher for adults under the "ACA with Medicaid expansion" scenario.

The second key ratios are the enrollment rates for the Medicaid/CHIP eligible population. It is expected that the enrollment rates will increase and therefore be higher for those currently eligible under the "ACA without Medicaid expansion" scenario compared to the baseline (No ACA). It is also expected that the enrollment rates will be higher for those currently eligible under the "ACA with Medicaid expansion" scenario compared to the "ACA without Medicaid expansion" scenario.

Step 2: Develop baseline key ratios by major Medicaid/CHIP eligibility group (no ACA)

According to the types of eligibility rules under the current Medicaid/CHIP program, we divided the entire population into the following major eligibility groups:

TANF related groups:

- TANF Children under age 19;
- CHIP Children under age 19; and
- TANF Adults age 19-64 (parental/care giver requirement applies).

Non-TANF based groups (mainly medical condition based groups):

- Non-TANF Medicaid Children under age 19; and
- Non-TANF Medicaid Adults age 19-64.

Given the poverty based eligibility rules for TANF children and CHIP children and the known population distribution for each age group, Aon Hewitt calculated the two key ratios described in Step 1 above for these two groups based on the data inputs. The calculated baseline percentages of children eligible for TANF and CHIP are 24.13% and 25.12% respectively. The calculated baseline enrollment rates for TANF eligible children and CHIP eligible children are 84.33% and 21.07% respectively. Based on our understanding of the CHIP eligibility and enrollment process, the lower enrollment rates for CHIP children are likely due to the fact that CHIP eligible children come from families above 100% of the federal poverty level who are more likely to have other insurance. In addition, CHIP requirements for premium payment, status of previous coverage, and a waiting period for families above 200% FPL who voluntarily drop other coverage are likely to further limit the enrollment rates for CHIP.

TANF Adults are currently defined as parents or caregivers age 19-64 with income below 32% FPL. Because of the limited income level and the instability of the population within this range, the distribution data developed from CPS data is not likely to be credible even after applying the 5-year smoothing process noted above. In addition, the average childless adult ratio developed across all income levels may not apply to this very low income adult group. Therefore, the percentage of adults eligible for TANF was based on a slightly different approach than what was used for the other TANF related groups (TANF children and CHIP children). First, we assumed the enrollment rate for this group to be the same as the overall TANF children enrollment rate (84.33%) given they have the same access to Medicaid coverage as their children. Second, based on the number of enrolled TANF adults and the assumed enrollment rate (84.33%), we calculated the baseline percentage of adults eligible for TANF to be 1.63%.

We applied a similar approach to the Non-TANF groups (Non-TANF Medicaid Adults and Non-TANF Medicaid Children) to calculate the eligible percentages and enrollment rates. The Non-TANF groups are eligible for Medicaid due, in part, to medical condition and are likely to actively seek health care coverage. Therefore, they are more likely to enroll in Medicaid than the TANF population when they become eligible. However, we do not expect all Non-TANF eligible individuals would enroll in Medicaid since not all eligible enrollees may understand that they can be eligible for Medicaid if they meet certain requirements. Based on these considerations, the enrollment rate for Non-TANF Medicaid Adults and Non-TANF Medicaid Children was assumed to be 90%, higher than the baseline enrollment rate (84.33%) for the TANF

population. Using the same method as the one for TANF adults, the baseline percentages of adults and children eligible for Non-TANF categories were calculated to be 4.54% and 4.44% respectively.

Exhibit 1 provides a summary of these 2 key baseline (No ACA) ratios for each eligibility group.

Step 3: Develop expected key ratios under ACA scenarios by major Medicaid/CHIP eligibility group

As we discussed in Step 1, the percentages of the entire population eligible for Medicaid/CHIP will be the same for the baseline (No ACA) and the ACA without Medicaid expansion scenario. Under the ACA with Medicaid expansion scenario, this percentage will not change for children but will increase for adults (age 19-64) due to the coverage of all adults through 138% FPL. According to the population distribution calculated using CPS data, the percentage of adults below 138% FPL is 16.88%. The percentage of adults who become newly eligible for Medicaid will be the difference between 16.88% and the percentage of adults below 138% FPL who are currently eligible for Medicaid (TANF Adults and Part of Non-TANF Adults). As calculated in Step 2, eligible TANF Adults account for 1.63% of all adults and eligible Non-TANF Adults account for 4.54% of all adults. We know that all eligible TANF adults are under 138% FPL and the majority of Non-TANF Adults are under 138% FPL. Based on our best knowledge of the eligibility rules for Non-TANF adults, we assumed 20% of them are above 138% FPL. Therefore, the newly eligible adults are estimated to be 11.62% (16.88% - 1.63% - 80%*4.54%) of all adults. To identify the adults under 138% FPL who may become eligible for the State Health Insurance Exchange under the ACA without Medicaid expansion scenario, we further break out the adults into three groups: below 100% FPL, below 138% FPL but above 100% FPL, and above 138% FPL. To identify the children who are currently eligible for CHIP and will become eligible for Medicaid under the ACA with Medicaid expansion scenario, we further break out the children under 237% into two groups: under 138% FPL and above 138% FPL. Exhibit 1 provides a summary of the first key ratio for each eligibility group under the ACA without Medicaid expansion scenario and the ACA with Medicaid expansion scenario.

In step 2, we developed the baseline enrollment rates for each major eligibility group. We estimate that the enrollment rates will increase under the ACA without Medicaid expansion scenario due to State outreach efforts, regardless of expansion. Based on discussions with the State, we expect the enrollment rates to increase even higher under the ACA with Medicaid expansion scenario because of extra outreach efforts initiated by various interest groups and the anticipated additional enrollment of currently eligible children when newly eligible parents enroll in Medicaid.

For the Medicaid population, the baseline enrollment rates are 84.33% for the TANF population and 90% for the Non-TANF population. Under the fully implemented ACA without Medicaid expansion scenario, we assumed the enrollment rates to increase to 92.50% for the TANF population and 95% for the Non-TANF population. Under the fully implemented ACA with Medicaid expansion scenario, we assumed the enrollment rates would increase slightly for those currently eligible for Medicaid due to the additional outreach efforts, but given the high baseline enrollment rates, the impact would be limited.

For the newly eligible Medicaid population, we expect the enrollment rate to be 74% when expansion is fully implemented. In developing the expected enrollment rate for newly eligible adults, we developed assumptions for two separate groups - newly eligible parents and newly eligible childless adults. We assumed the enrollment rate for newly eligible parents will be similar to the enrollment rate for the currently eligible TANF Children population. For the newly eligible childless adults, the expected

enrollment rate is estimated to be substantially lower. The weighted average expected enrollment rate for all newly eligible adults is estimated to be 74%. This results in an uninsured rate for age 19-64 below 138% FPL of 13%, which is similar to the Census estimate of uninsured for the same age group below 138% FPL in Massachusetts, the only state that currently has an individual mandate. Massachusetts provides a reasonable benchmark for the expected uninsured rate for this particular age group in the State of Kansas when the expansion is fully implemented.

For the CHIP population, the overall baseline enrollment rate from the population distribution is 21.07%. Under the ACA without Medicaid expansion scenario, we assumed the enrollment rate will increase to 30% due to the expected simplification of the CHIP enrollment process and outreach efforts along with increased public awareness of the CHIP program. Under the ACA with Medicaid expansion scenario, it is expected that the enrollment rate will vary for children under 138% FPL and above 138% FPL. For children above 138% FPL, we assumed that the enrollment rate will increase to 40% because of extra outreach efforts. For those CHIP eligible children above 100% FPL and below 138% FPL, who will now be eligible for Medicaid, we expect the enrollment rate to increase to 70% since some newly eligible parents above 100% but below 138% FPL are anticipated to drop non-Medicaid coverage and enroll in Medicaid with their children in CHIP or Medicaid. Exhibit 1 provides a summary of the second key ratio for each eligibility group under the ACA without Medicaid expansion scenario and the ACA with Medicaid expansion scenario.

Step 4: Calculate expected enrollment increase and budget increase under ACA scenarios by major Medicaid/CHIP eligibility group

As noted in step 3, all enrollment rate assumptions developed for the ACA scenarios represent our assumptions once the program is fully implemented. Our 10-year projections assume the following State provided implementation phase-in schedule: 50% for first year, 80% for second year, and 100% for the third year and beyond.

Based on the two key ratios calculated in step 3 and the projected total population for a particular year, the expected enrollment increase for each eligibility group can be calculated using the data inputs and assumptions summarized in Exhibit 1. Specifically, the enrollment increase for the currently eligible population is equal to the product of the phase-in schedule percentage, the estimated total adult/children population, percentage of currently eligible and the difference between the expected enrollment rate and the baseline enrollment rate. The enrollment increase for the newly eligible population is equal to the product of the phase-in schedule percentage, the estimated total population for adult/children, percentage of newly eligible and the expected enrollment rate.

To calculate the budget increase, we developed the expected per member per year (PMPY) costs for the newly enrolled individuals based on the expected PMPY costs of the currently enrolled. The CY14 costs for the currently enrolled population were trended forward assuming a 2.5% annual trend.

In developing the PMPY cost for those newly enrolled, we considered the similarities in terms of health care needs between the currently enrolled population and newly enrolled population. Since we modeled the enrollment and budget impact at the detailed eligibility group level, the expected PMPY cost was matched at the detailed eligibility group level except for the following two groups: currently eligible but newly enrolled Non-TANF adults, newly eligible and newly enrolled adults.

For the currently eligible but newly enrolled Non-TANF adults, the average costs are expected to be similar to the “Regular Non-TANF adults” who are disabled, pregnant, or medically needy rather than costs for the remaining Non-TANF adults who are labeled “Special Non-TANF adults”. As noted in the Data section of this report, these “Special Non-TANF adults” are unlikely to produce any woodwork effect under ACA scenarios, regardless of expansion. Therefore, the average costs for the currently eligible but newly enrolled Non-TANF adults are based on the average costs of the “Regular Non-TANF adults” only.

For the newly eligible and newly enrolled adults, the average costs are expected to be similar to those of TANF adults, assuming no material differences in the benefit package offered. The analysis assumes no material differences in the benefit package offered since changes to benefits are not specifically known at this point. It is anticipated that most of the individuals in this group are either covered by non-Medicaid insurance or are currently uninsured. Based on experiences in other states that have expanded Medicaid to individuals with higher incomes, there may be some pent up demand for health care services for those currently uninsured and newly enrolled in the initial years, which should then reduce in later years. Therefore, we assumed that the costs for the newly eligible and newly enrolled adults are on average consistent to the costs of current TANF adults over the ten year projection period beyond 2014.

The expected total budget increase (state share and federal share combined) for a particular eligibility group in a particular projection year is equal to the product of the corresponding enrollment increase and the projected PMPY cost. The federal share of the budget increase is calculated by applying the corresponding Federal Medical Assistance Percentage (FMAP) rate. The State share of the budget increase is calculated by applying the corresponding State Medical Assistance Percentage (SMAP) rate. FMAP rates will vary for the current eligibles and the newly eligibles by year. For the newly eligible population, the FMAP rate is 100% from 2014 through 2016 and then gradually decreases to 90% in 2020 and beyond. Current Medicaid FMAP rates were assumed to be stable over the 10 year projection period for the current eligible Medicaid and CHIP populations.

Results

The results are summarized in the attached Exhibit 2 at an aggregate level for each projection year, CY2014 through CY2023.

Assuming moderate statewide population growth will continue, and using the CY2010 Medicaid/CHIP enrollment experience as a base, our best estimate if the State chooses not to expand Medicaid, is that the Medicaid/CHIP enrollment will increase by 20,563 in CY2014, ramping up to 41,538 (23,740 for Medicaid and 17,798 for CHIP) by CY2016, when the ACA is expected to be fully implemented. The increase in enrollment without expansion is assumed to occur due to outreach efforts under ACA implementation, regardless of expansion. This expected increase in enrollment for those who are currently eligible but not enrolled in the Medicaid/CHIP program is commonly referred to as the woodwork effect. The anticipated 10-year (CY2014-CY2023) State budget increase (state share only) for no expansion will be $513.5M ($455.5M for Medicaid and $58.0M for CHIP).

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The best estimate reflects our interpretation of the available data and our best assumptions regarding how various eligible beneficiaries will react to the implementation per our discussions with the State. The budget impact did not account for possible options to reclassify some currently eligible beneficiaries to newly eligible status to gain higher FMAP or potential reductions in state-only programs, and it also did not account for additional administrative costs associated with an expansion. Our enrollment and budget impact also assumed that ACA implementation has no material impact to those individuals age 65 and over.

We would like to thank the State of Kansas Department of Health and Environment for their assistance in providing data and responding to questions regarding current eligibility processes in the state of Kansas. We would also like to thank Maria Dominiak, FSA, MAAA of Airam Actuarial Consulting and Roberta Bradford of Bradford Advisors, for providing technical guidance and review.

Exhibit 1 - State of Kansas ACA Enrollment and Budget Impact Analysis Key Data Inputs and Assumptions

Demographic and Economic Factors	
Population Growth	0.50%
PMPY Trend	2.50%
Under Age 19 (CY2010 Census)	769,880
Age 19-64 (2010 Census)	1,707,122

ACA Phase-In Schedule	
CY2014	50%
CY2015	80%
CY2016-2023	100%

Average Capitation Rates	CY2014 PMPM	CY2014 PMPY
Medicaid TANF Children	$ 176.69	$ 2,120.31
Medicaid Non-TANF Children	$ 858.42	$ 10,301.00
Medicaid TANF Adults	$ 377.33	$ 4,528.00
Regular Non-TANF Adults	$ 772.63	$ 9,271.57
Special Non-TANF Adults	$ 3,490.86	$ 41,890.31
CHIP Children	$ 112.76	$ 1,353.07

FMAP	Medicaid Current Eligible	Medicaid Newly Eligible	CHIP Eligible (>138% FPL)	CHIP Eligible (<138% FPL)
2014	56.80%	100.00%	69.80%	69.80%
2015	56.80%	100.00%	69.80%	69.80%
2016	56.80%	100.00%	92.80%	69.80%
2017	56.80%	95.00%	92.80%	69.80%
2018	56.80%	94.00%	92.80%	69.80%
2019	56.80%	93.00%	92.80%	69.80%
2020	56.80%	90.00%	69.80%	69.80%
2021	56.80%	90.00%	69.80%	69.80%
2022	56.80%	90.00%	69.80%	69.80%
2023	56.80%	90.00%	69.80%	69.80%

Medicaid/CHIP Eligible Rate (First Key Ratio)	No ACA	ACA without Expansion	ACA with Expansion	
Medicaid Population	Current Eligible	Current Eligible	Current Eligible	Newly Eligible
Under 19				
- TANF Children	24.13%	24.13%	24.13%	0.00%
- Non-TANF Children	4.44%	4.44%	4.44%	0.00%
Age 19-64				
- TANF Adults (<38% FPL)	1.63%	1.63%	1.63%	0.00%
- Non-TANF Adults (0%-99% FPL)	2.48%	2.48%	2.48%	7.93%
- Non-TANF Adults (100%-138% FPL)	1.15%	1.15%	1.15%	3.68%
- Non-TANF Adults (>138% FPL)	0.91%	0.91%	0.91%	0.00%
CHIP Population				
Under 19				
Under 19 < 138% FPL	4.90%	4.90%	4.90%	0.00%
Under 19 > 138% FPL	20.22%	20.22%	20.22%	0.00%

Enrollment Rate For The Medicaid/CHIP Eligible (Second Key Ratio)	No ACA	ACA without Expansion	ACA with Expansion	
Medicaid Population	Current Eligible	Current Eligible	Current Eligible	Newly Eligible
Under 19				
- TANF Children	84.33%	92.50%	93.00%	
- Non-TANF Children	90.00%	95.00%	95.50%	
Age 19-64				
- TANF Adults (<38% FPL)	84.33%	92.50%	93.00%	
- Non-TANF Adults (0%-99% FPL)	90.00%	95.00%	95.50%	74.00%
- Non-TANF Adults (100%-138% FPL)	90.00%	95.00%	95.50%	74.00%
- Non-TANF Adults (>138% FPL)	90.00%	95.00%	95.50%	
CHIP Population				
Under 19				
Under 19 < 138% FPL	20.96%	30.00%	70.00%	
Under 19 > 138% FPL	21.09%	30.00%	40.00%	

Exhibit 2 - State of Kansas ACA Enrollment and Budget Impact Results Projected With Aon Hewitt's Best Estimate

Medicaid Budget Impact		ACA Without Medicaid Expansion			ACA With Medicaid Expansion						ACA with Expansion vs No-ACA		
CY	Age Group	Enrollment Increase	State Budget Increase	Federal Budget Increase	Incremental Enrollment Increase from current eligible	Incremental State Budget Increase from current eligible	Incremental Federal Budget Increase from current eligible	Enrollment Increase from newly Eligible	State Budget Increase from newly eligible	Federal Budget Increase from newly eligible	Enrollment Increase	State Budget Increase	Federal Budget Increase
2014	Under Age 65	11,752	$ 21,159,642	$ 27,821,011	830	$ 1,752,685	$ 2,304,456	74,851	-	$ 338,925,292.93	87,433	$ 22,912,327	$ 369,050,760
2015	Under Age 65	18,897	$ 34,875,322	$ 45,854,590	1,334	$ 2,888,776	$ 3,798,205	120,360	-	$ 558,616,667.80	140,592	$ 37,764,097	$ 608,269,462
2016	Under Age 65	23,740	$ 44,907,426	$ 59,044,949	1,676	$ 3,719,750	$ 4,890,782	151,203	-	$ 719,306,243.65	176,618	$ 48,627,176	$ 783,241,975
2017	Under Age 65	23,858	$ 46,260,262	$ 60,823,678	1,684	$ 3,831,808	$ 5,038,117	151,959	37,048,767	$ 703,926,577.03	177,501	$ 87,140,837	$ 769,788,372
2018	Under Age 65	23,978	$ 47,653,853	$ 62,655,991	1,693	$ 3,947,241	$ 5,189,891	152,718	45,797,834	$ 717,499,392.89	178,389	$ 97,398,927	$ 785,345,275
2019	Under Age 65	24,098	$ 49,089,425	$ 64,543,503	1,701	$ 4,066,151	$ 5,346,236	153,482	55,040,409	$ 731,251,146.55	179,281	$ 108,195,985	$ 801,140,886
2020	Under Age 65	24,218	$ 50,568,244	$ 66,487,876	1,710	$ 4,188,644	$ 5,507,291	154,249	80,997,859	$ 728,980,729.68	180,177	$ 135,754,747	$ 800,975,897
2021	Under Age 65	24,339	$ 52,091,612	$ 68,490,823	1,718	$ 4,314,827	$ 5,673,199	155,021	83,437,919	$ 750,941,274.17	181,078	$ 139,844,358	$ 825,105,296
2022	Under Age 65	24,461	$ 53,660,872	$ 70,554,109	1,727	$ 4,444,811	$ 5,844,104	155,796	85,951,487	$ 773,563,380.05	181,984	$ 144,057,170	$ 849,961,593
2023	Under Age 65	24,583	$ 55,277,406	$ 72,679,552	1,735	$ 4,578,711	$ 6,020,157	156,575	88,540,775	$ 796,866,976.87	182,893	$ 148,396,892	$ 875,566,686
2014-2023	**Under Age 65**		**$ 455,544,062**	**$ 598,956,082**		**$ 37,733,404**	**$ 49,612,439**		**$ 476,815,050**	**$ 6,819,877,682**		**$ 970,092,516**	**$ 7,468,446,202**

CHIP Budget Impact		ACA Without Medicaid Expansion			ACA With Medicaid Expansion						ACA with Expansion vs No-ACA		
CY	Age Group	Enrollment Increase	State Budget Increase	Federal Budget Increase	Incremental Enrollment Increase from current eligible	Incremental State Budget Increase from current eligible	Incremental Federal Budget Increase from current eligible	Enrollment Increase from newly Eligible	State Budget Increase from newly eligible	Federal Budget Increase from newly eligible	Enrollment Increase	State Budget Increase	Federal Budget Increase
2014	Under Age 19	8,811	$ 3,600,368	$ 8,321,380	15,636	$ 6,389,365	$ 14,767,474				24,447	$ 9,989,733	$ 23,088,854
2015	Under Age 19	14,168	$ 5,934,126	$ 13,715,299	25,143	$ 10,530,952	$ 24,339,750				39,311	$ 16,465,078	$ 38,055,049
2016	Under Age 19	17,798	$ 2,970,389	$ 22,331,316	31,586	$ 8,315,196	$ 36,586,281				49,384	$ 11,285,585	$ 58,917,598
2017	Under Age 19	17,887	$ 3,059,872	$ 23,004,047	31,744	$ 8,565,691	$ 37,688,443				49,631	$ 11,625,563	$ 60,692,490
2018	Under Age 19	17,977	$ 3,152,050	$ 23,697,044	31,903	$ 8,823,733	$ 38,823,807				49,879	$ 11,975,783	$ 62,520,852
2019	Under Age 19	18,067	$ 3,247,006	$ 24,410,918	32,062	$ 9,089,548	$ 39,993,375				50,129	$ 12,336,554	$ 64,404,292
2020	Under Age 19	18,157	$ 8,604,318	$ 19,886,801	32,222	$ 15,269,587	$ 35,291,959				50,380	$ 23,873,905	$ 55,178,760
2021	Under Age 19	18,248	$ 8,863,523	$ 20,485,891	32,384	$ 15,729,583	$ 36,355,129				50,631	$ 24,593,106	$ 56,841,020
2022	Under Age 19	18,339	$ 9,130,537	$ 21,103,028	32,545	$ 16,203,437	$ 37,450,327				50,885	$ 25,333,973	$ 58,553,355
2023	Under Age 19	18,431	$ 9,405,594	$ 21,738,757	32,708	$ 16,691,565	$ 38,578,518				51,139	$ 26,097,159	$ 60,317,275
2014-2023	**Under Age 19**		**$ 57,967,783**	**$ 198,694,481**		**$ 115,608,658**	**$ 339,875,064**					**$ 173,576,440**	**$ 538,569,545**

Medicaid/CHIP Budget Impact		ACA Without Medicaid Expansion			ACA With Medicaid Expansion						ACA with Expansion vs No-ACA		
CY	Age Group	Enrollment Increase	State Budget Increase	Federal Budget Increase	Incremental Enrollment Increase from current eligible	Incremental State Budget Increase from current eligible	Incremental Federal Budget Increase from current eligible	Enrollment Increase from newly Eligible	State Budget Increase from newly eligible	Federal Budget Increase from newly eligible	Enrollment Increase	State Budget Increase	Federal Budget Increase
2014	Under Age 65	20,563	$ 24,760,010	$ 36,142,391	16,466	$ 8,142,051	$ 17,071,930	74,851	-	$ 338,925,292.93	111,880	$ 32,902,060	$ 392,139,614
2015	Under Age 65	33,065	$ 40,809,448	$ 59,569,888	26,477	$ 13,419,728	$ 28,137,955	120,360	-	$ 558,616,667.80	179,903	$ 54,229,176	$ 646,324,511
2016	Under Age 65	41,538	$ 47,877,815	$ 81,376,265	33,262	$ 12,034,946	$ 41,477,064	151,203	-	$ 719,306,243.65	226,003	$ 59,912,761	$ 842,159,573
2017	Under Age 65	41,746	$ 49,320,134	$ 83,827,725	33,428	$ 12,397,499	$ 42,726,560	151,959	37,048,767	$ 703,926,577.03	227,133	$ 98,766,400	$ 830,480,863
2018	Under Age 65	41,955	$ 50,805,903	$ 86,353,035	33,595	$ 12,770,974	$ 44,013,698	152,718	45,797,834	$ 717,499,392.89	228,268	$ 109,374,710	$ 847,866,126
2019	Under Age 65	42,164	$ 52,336,431	$ 88,954,421	33,763	$ 13,155,699	$ 45,339,611	153,482	55,040,409	$ 731,251,146.55	229,410	$ 120,532,539	$ 865,545,178
2020	Under Age 65	42,375	$ 59,172,562	$ 86,374,677	33,932	$ 19,458,231	$ 40,799,250	154,249	80,997,859	$ 728,980,729.68	230,557	$ 159,628,651	$ 856,154,657
2021	Under Age 65	42,587	$ 60,955,135	$ 88,976,714	34,102	$ 20,044,410	$ 42,028,328	155,021	83,437,919	$ 750,941,274.17	231,710	$ 164,437,464	$ 881,946,316
2022	Under Age 65	42,800	$ 62,791,408	$ 91,657,137	34,272	$ 20,648,248	$ 43,294,431	155,796	85,951,487	$ 773,563,380.05	232,868	$ 169,391,143	$ 908,514,948
2023	Under Age 65	43,014	$ 64,683,000	$ 94,418,309	34,444	$ 21,270,276	$ 44,598,676	156,575	88,540,775	$ 796,866,976.87	234,032	$ 174,494,051	$ 935,883,961
2014-2023	**Under Age 65**		**$ 513,511,845**	**$ 797,650,563**		**$ 153,342,062**	**$ 389,487,503**		**$ 476,815,050**	**$ 6,819,877,682**		**$ 1,143,668,956**	**$ 8,007,015,747**

Medicaid Budget Impact		ACA Without Medicaid Expansion			ACA With Medicaid Expansion						ACA with Expansion vs No-ACA		
CY	Age Group	Enrollment Increase	State Budget Increase	Federal Budget Increase	Incremental Enrollment Increase from current eligible	Incremental State Budget Increase from current eligible	Incremental Federal Budget Increase from current eligible	Enrollment Increase from newly Eligible	State Budget Increase from newly eligible	Federal Budget Increase from newly eligible	Enrollment Increase	State Budget Increase	Federal Budget Increase
2014	Age 19-64 (100-138% FPL)	502	$ 2,010,322	$ 2,643,201	50	$ 201,032	$ 264,320	23,737	-	$ 107,481,649.65	24,289	$ 2,211,354	$ 110,389,171
2015	Age 19-64 (100-138% FPL)	807	$ 3,313,413	$ 4,356,524	81	$ 331,341	$ 435,652	38,169	-	$ 177,151,254.96	39,057	$ 3,644,754	$ 181,943,432
2016	Age 19-64 (100-138% FPL)	1,014	$ 4,266,537	$ 5,609,706	101	$ 426,654	$ 560,971	47,950	-	$ 228,109,920.64	49,065	$ 4,693,190	$ 234,280,597
2017	Age 19-64 (100-138% FPL)	1,019	$ 4,395,066	$ 5,778,698	102	$ 439,507	$ 577,870	48,190	11,749,087	$ 223,232,645.40	49,311	$ 16,583,659	$ 229,589,213
2018	Age 19-64 (100-138% FPL)	1,024	$ 4,527,467	$ 5,952,781	102	$ 452,747	$ 595,278	48,431	14,523,633	$ 227,536,923.28	49,557	$ 19,503,848	$ 234,084,983
2019	Age 19-64 (100-138% FPL)	1,029	$ 4,663,857	$ 6,132,109	103	$ 466,386	$ 613,211	48,673	17,454,684	$ 231,897,946.78	49,805	$ 22,584,927	$ 238,643,267
2020	Age 19-64 (100-138% FPL)	1,034	$ 4,804,356	$ 6,316,839	103	$ 480,436	$ 631,684	48,916	25,686,438	$ 231,177,941.06	50,054	$ 30,971,230	$ 238,126,464
2021	Age 19-64 (100-138% FPL)	1,039	$ 4,949,087	$ 6,507,133	104	$ 494,909	$ 650,713	49,161	26,460,242	$ 238,142,176.54	50,304	$ 31,904,238	$ 245,300,023
2022	Age 19-64 (100-138% FPL)	1,045	$ 5,098,179	$ 6,703,161	104	$ 509,818	$ 670,316	49,407	27,257,357	$ 245,316,209.60	50,556	$ 32,865,353	$ 252,689,686
2023	Age 19-64 (100-138% FPL)	1,050	$ 5,251,761	$ 6,905,093	105	$ 525,176	$ 690,509	49,654	28,078,484	$ 252,706,360.42	50,809	$ 33,855,422	$ 260,301,963
2014-2023	**Age 19-64 (100-138% FPL)**		**$ 43,280,046**	**$ 56,905,246**		**$ 4,328,005**	**$ 5,690,525**		**$ 151,209,925**	**$ 2,162,753,028**		**$ 198,817,976**	**$ 2,225,348,798**